DOCUMENT RESUME

ED 149 254 CG 012 290

AUTHOR Martin, Murray A.; Downs, Barbara
TITLE The Implementation of a System of Care in British Columbia.
INSTITUTION Alcohol and Drug Commission of British Columbia, Vancouver (Canada).
PUB DATE May 77
NOTE 31p.

EDRS PRICE MF-$0.83 HC-$2.06 Plus Postage.
DESCRIPTORS *Administrative Principles; *Alcohol Education; *Drug Abuse; *Financial Support; Legislation; Program Descriptions; *Rehabilitation Centers; Social Services
IDENTIFIERS *British Columbia

ABSTRACT

This presentation documents the process of the implementation of a System of Care in British Columbia, 1973-1977. Several mechanisms of implementation are described, including the Monitoring System, Fiscal Accountability, Program Liaison, Program Guidelines, Program Description Manual, Classification System, Funding Agreement, and Regionalization. The emphasis is on the process of consultation with line staff. Generation of descriptions of the components of the System of Care from the programs already in existence are discussed. The format for thinking about programs used for the Guidelines is extensively described. This format is composed of six key questions, the answers to which form the basis for the three main components of a System of Care: Detoxication, Out-Patient, and Residential Services. These questions are: (1) What is the rationale for this program? (2) What are the program objectives and goals? (3) Who is the client? (4) What happens to the client in treatment? (5) What is the staff organization and how does it function? and (6) What is the referral path and the follow-up procedure? These questions may also be used as guides for staff development and for program assessment. (Author/MFD)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED149254

THE IMPLEMENTATION OF A SYSTEM OF CARE IN BRITISH COLUMBIA

Murray A. Martin and Barbara Downs
Program Liaison Division

April, 1977

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
NATIONAL INSTITUTE OF EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Alcohol & Drug Commission of B.C.
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

Province of British Columbia
Ministry of Health
Alcohol and Drug Commission

CG 012290

THE IMPLEMENTATION OF A SYSTEM OF CARE

IN BRITISH COLUMBIA

Murray A. Martin and Barbara Downs
Program Liaison Division

April 1977

© Copyright May 1977 Alcohol and Drug Commission
of British Columbia

Do not quote or cite more than limited excerpts of this report. Reproduction of long passages or the total report requires the written permission of the Chairman of the Alcohol and Drug Commission.

The Alcohol and Drug Commission
of British Columbia
805 W. Broadway
7th Floor
Vancouver, B.C.
V5Y 1P9

THE IMPLEMENTATION OF A SYSTEM OF CARE

IN BRITISH COLUMBIA

The Background For Developing The System of Care.

In 1973 there were 84 agencies, including the two major foundations for drugs and alcohol, throughout the Province of British Columbia, offering a variety of services for people who had problems with chemical dependency. These services included crisis centres, drop-in centres, half-way houses; "preventative", information and education programs; residential and counselling services.

Funding for these programs was generated from a variety of local, provincial and federal sources. It is not difficult to assume that there was minimal accountability and uncertain consistency in the services provided. Funding was often for duplicate services, for services with a too narrowly defined clientele, or, at the other extreme, services that were so "global" in their objectives - being "all things to all people" - that they were ineffective.

Some of the services were geared to a narrow ideology or "solution" to the problems associated with drugs and alcohol; some of these services depended on the "charisma" or vision of a single individual. Often the attitude of staff people

in these programs was: "we know what the needs are and we know what the solutions are; give us the money to do our work and leave us alone". One could conclude that under these circumstances one would find gaps in service, over-service, inconsistency and ineffectiveness. While some of the agencies had developed into competent and appropriate services there were many instances of an ineffective allocation of resources.

What was needed in the Province was a coherent way of conceptualizing services in the treatment of drug and alcohol-related problems. This process would require a definition of the services required, the establishment of standards for programs and for staff and the development of mechanisms of implementation such as consultation with local groups on the problems to be dealt with and the appropriate responses in terms of treatment service, the development of funding priorities and the development of methods of program review and evaluation.

The Commission Mandate

The Alcohol and Drug Commission was created by the Provincial Government in 1973 and the Act establishing it gave it the authority to provide and co-ordinate treatment and rehabilitation services for individuals with drug or alcohol related problems. From the beginning the Commission was expected to bring some order out of the plethora of services and to begin to develop effective responses to the very prevalent problems of alcoholism and drug abuse. In approaching this task it was inadvisable and impractical to "wipe the slate clean" and start again. The reality was that while some of the existing services were inappropriate they were all that was being offered and employed the only people with any experience in the field.

The concept of a System of Care was adopted in order to guide the Commission's development of programs. With respect to alcoholics the system designated detox, intensive residential treatment centres, out-patient counselling and long-term supportive care as the core components of the program. With respect to narcotic addicts no real system was defined but the type of services being offered were defined.

In 1976 this process went a step further and each of the elements in the System of Care were described in considerable detail as will be outlined in the following pages. A comprehensive document called the Program Guidelines was developed which described program, staff, and clients of detox, residential treatment, outpatient counselling, supportive residences, and methadone clinics. These program descriptions represented the Commission's statement of what is expected of programs in the province and was used as a base line for all discussions with individual programs.

Also in 1976 the concept of regionalization was introduced to simplify the task of planning and implementing programs on a provincial basis. The province was divided into four large regions and the Commission committed itself to completing the System of Care in each of these regions.

Implementation

The concept of a System of Care is itself not new. The services appropriate to various stages of alcoholism have been recognized elsewhere. The process of developing such a system, however, is not a simple one and a tremendous effort has gone into developing existing and new programs in British Columbia into a system.

Not everyone in the field shares the same view of the services that are required nor how those services should be provided. The implementation of a System of Care requires extensive discussion with workers in the field to come to a mutually satsifactory definition of what variety of treatment services should be provided and how. The rest of this paper lays out how that discussion was structured and carried out between the Alcohol and Drug Commission of British Columbia and the agencies we fund that provide the services.

Direct Service and Funded Agencies

The Alcohol and Drug Commission of British Columbia uses two administrative mechanisms for providing service: Direct Service and Funded Agencies. Direct Service Programs are funded and administered by the Commission itself; direct service includes a detox facility, the major drug and alcohol services in the Lower Mainland and other Out-Patient facilities in the province. Of the 51 programs in the province, funded by the Commission, 9 are "direct service". The other 42 programs are administered by private Societies and Boards. Other provinces fund programs by a variety of administrative mechanisms. The point to be made is that a System of Care operates as an entity regardless of the funding and administrative mechanisms.

Lines of Communication

A System of Care can only work as well as the lines of communication between the various components. Aside from the program to program communication mechanisms which we will mention (regional workshops, Program Description Manual) the Commission communicates administratively with the Boards or Societies of the funded agencies and with the programs by way of the Program Liaison Division and other divisions of the Commission Staff.

Mechanisms of the System of Care

Among the initiatives which the Alcohol and Drug Commission has taken to implement an effective System of Care are the following mechanisms - some of which will be discussed at length in this paper:

The Monitoring System: since 1975 the Monitoring System has provided data on all client-initiated requests for treatment. (For a complete discussion of the Monitoring System refer to Hollander, M.J., The Client/Agency Monitoring System of the Alcohol and Drug Commission of British Columbia.)

Fiscal Accountability: since 1975 the Administrative Division of the Alcohol and Drug Commission has required monthly reports of expenditures and an annual audit from

the funded agencies.

Program Liaison Division: in 1976 the Commission created this division of the Commission Staff to liaise with the staff people of 42 funded programs in the Province.

Program Guidelines: in 1976 the Commission developed a description of the basic components of the System of Care.

Program Description Manual: in 1977 the Commission produced a brief description of each service within the System of Care for general distribution.

Classification System: in 1977 the Commission developed a classification system based on qualification for positions within the system of treatment services.

Funding "Agreement": in 1977 funding was made conditional upon an agreement between the Boards and the Commission that a program is funded for well-defined services. (In the System of Care it is important that there be no ambiguity about the service for which each program is funded.)

Regionalization: in 1976 the Commission divided the Province into four regions for the purpose of providing a comprehensive System of Care for each region.

Developmental Questions for the System of Care

When it comes to the practical matter of implementing a System of Care there is an indefinite list of questions to be asked:

What is a realistic assessment of the problem in chemical dependency in an area or region? What kinds of programs will be the best responses to these problems?

Who are the clients who will be served by a particular program, what are the admission criteria and how will they be assessed?

What treatment approaches are going to be used? In what facilities? In what locations?

How will a particular service relate to other treatment resources and community agencies in the area and in the region?

What will be the qualifications of the staff and how can quality of service be promoted through the training and development of that staff?

How will the effectiveness of the service delivered be determined?

How will it be determined that the service agreed upon is the service delivered?

Is the service an appropriate one for the clients and for the needs of the area?

What kind of follow-up and after-care can be developed?

How will this program or staff relate to its administrative or supervisory body? What will be the lines of communication?

Are a given number of treatment programs the best use of resources available: that is, the financial resources, the staff people, the facilities and, quite importantly, the resource of public awareness and interest?

These, and allied, questions must be answered with a degree of consistency so that staff time and energy can be devoted to service instead of being dissipated in confusion over roles and expectations. This is an important justification for a System of Care: that it free the treatment staff to deliver the service.

Major Components

The first task was to define the major components of a System of Care.* These components correspond to the major phases of treatment which an individual is likely to require. These components are Detox, Residential and Out-Patient services, with the Out-Patient service considered as the referral and follow-up component, the "traffic manager" of the system. The Guidelines were developed by the Commission as a means of describing in detail the standards which were expected of basic components of the System of Care. In general, these descriptions provide guidance in answering most of the questions which arise in connection with what constitutes a Detox, Residential or Out-Patient service. In the spring of 1976 the Commission directed the 2 members of Program Liaison to be in charge of developing these guidelines.

The "Format"

We organized our thinking about service programs under six basic questions which we called the "format". These questions form a "pathway" for thinking about programs which can be shared by everyone who is concerned about or related to the System of Care.

*Based on policy papers developed by the Commission in 1974.

The advantage of the "format" is that it ties together both treatment and the programs which are the structure of treatment. The "format" is a method of bringing together, in one document, the considerable experience of those staff people (or line workers) who have been providing the service in a variety of programs.

The responses to the "format questions" constitute the basic program descriptions of the major components of the System of Care, that is, Detox, Out-Patient and Residential Services. These basic program descriptions provide the standards for a particular type of service. The individual program description is developed with reference to these standards. An evaluation process can be developed from these basic program descriptions.

As we go through the "format" each question builds on the previous question so that there is coherence and consistency in the responses. The rigorousness with which the program is consistent in its answers is one means of determining whether effective treatment is taking place. That is, are the goals and objectives consistent with the identified needs? Does the program serve the clients for whom the program was designed? Are the treatment processes consistent with the objectives of the program? Is the staff qualified to provide the treatment which is seen as the proper response and are they, in fact, providing that treatment? Is there

adequate provision for proper referrals, follow-up and program evaluation?

The "format questions" are as follows:

I. WHAT IS THE RATIONALE FOR THIS PROGRAM?

The "rationale question" is the pivotal question in this exercise. Its purpose is to establish and document the needs of an area or of a group of potential clients. It is a correction to programs which are developed by over-enthusiastic individuals or groups who are narrowly focused on either the problem or the solution.

Therefore, we want documentation from a variety of sources such as police statistics, hosptial records, a variety of social service agencies and other community groups, and by groups of potential clients, that a particular series of problems exist in an area and the extent to which they exist.

For example, if there is drug-abuse among teenagers in a small city, is it a large or small group, associated with one or more areas of the community, using what drugs? Where does the information come from? Is the appropriate response a drop-in centre, more recreation, an educational effort associated with the schools, a "preventative" program sponsored by a religious or other group, or a short or long term residential setting?

When we are talking about the needs of an area we want to know where the information comes from, what individuals or groups have identified the problem.

If this is an existing program, we want to know what kind of continuing contact this program has with a variety of social service and community groups so that the program is visible to the community, that there is general knowledge about the program in the community, that the program is getting feedback from the community as to whether it remains a relevant program and an effective program. Changing information about the problems should lead to a change in the program itself. For instance, the "youth-oriented crisis-centres" no longer have the relevance that they had in the late sixties and early seventies, because the population is more knowledgeable about drugs and their effects.

It is important to know whether a program is a significant resource for other social agencies and community groups or whether it operates in isolation. It is important to know whether a program appropriately uses the resources available in the community or tries to do the whole job by itself.

What are the geographical limits of the program? Does it serve a well-defined area or does it attempt to reach such a wide area that it does not concentrate well enough on

a particular group of clients and spreads the time and energy of the staff thin with too large a workload with unrealistic hours and distances?

A summary question is, given the identified and documented needs of an area, is this projected or present program the most appropriate response to the problem and is so perceived by significant segments of the community?

The "rationale" question is a program development and staff development question. Staff people need to periodically question the relevance of their program and its treatment process to the clients and the area which they are serving. It is impossible to over-estimate the importance of this kind of review, not least by the people who are providing the service, and certainly by those in charge of the overall funding and program development in a System of Care.

II. WHAT ARE THE GOALS AND OBJECTIVES OF THE PROGRAM?

Do the Goals and Objectives support the program which is a response to the identified needs in question #I? For instance, it may be determined that severe drinking problems are disruptive in the industrial, family and social life of a certain number of people in a community. What is needed is a program for such people in order that they be confronted with the need to make decisions about their drinking and

be supported in their recovery. For the majority of problem drinkers recovery alone may achieve work and family and social stability. The Program designed for this problem would be a Supportive Residential Centre; the Goal of the program would be sobriety and the Objectives would be to help people maintain their recovery and develop social stability.

There may be secondary objectives to treatment such as the need of an Out-Patient service to develop community awareness of its service, to provide information on drugs and alcohol to the community, to provide educational or "awareness" presentations to various segments of the community and to be familiar with and work well with a variety of referral sources and resources.

This question is an opportunity for sorting out priorities, to make sure that someone is not delivering gratifying public presentations rather than concentrating on the sometimes less than dramatic treatment aspects of the program.

III. WHO IS THE CLIENT?

The question is, who is the appropriate client for this service? Most programs cannot be effectively designed to deliver service to everyone of any age who "needs help".

Good treatment cannot be designed to respond to certain problem areas without a clear idea of the clients who will utilize the service.

For this reason the admission criteria should be clear to the staff of the program and to those who will use the program as a resource. For example, it is an inappropriate use of facilities to send a client to an "intensive treatment centre" who does not have the verbal and social skills to utilize the training in "life skills" which is often a part of such programs.

It is also important for the program to define the clients and the problems with which it cannot work, such as severe depression or mental disorders.

Another part of the description of the client section is a general description of the "client population" or "target group" to which a service is addressing itself. For example, a Residential Treatment Service may gear its program to the "attached alcoholic" who has a record of job stability, rather than those who have been on skid row, with no recent job or family connections.

The staff should think very carefully about the people for whom they are designing the program and then should attempt to do an effective job with those people, given their presenting problems.

It is essential that the staff continue to develop their assessment skills, so that they will understand the needs of the client, be able to respond in the most appropriate way, or refer the client on when their own service is inappropriate.

IV. WHAT HAPPENS TO THE CLIENT IN TREATMENT?

This two-part question attempts to link treatment with "management" so that they are consistent with each other. For example, if the object of treatment is to teach people to be responsible for themselves, then, in a residential centre, the individual is required to participate fully in the housekeeping and make himself presentable; in an out-patient service people are expected to be on time and not be overdependent on the counsellor to do things for them.

IV. A. WHAT TREATMENT ASSUMPTIONS/PHILOSOPHY, MODELS, PROCESSES AND SKILLS ARE USED IN THIS PROGRAM?

These four components cohere very tightly together, as treatment is seen to respond to well-defined needs, with commensurate goals and objectives for a definite client population.

Well articulated assumptions and philosophy have implications for the smallest detail of treatment, including the training and attitudes of the staff. It is not a waste of time for the staff to periodically examine their perspective on treatment. It is not good enough to say that an assumption of treatment is "for people to be responsible for their own behaviour" without re-examining what is meant by that well-worn phrase and what it's implications are for the staff members themselves.

The models of treatment should be mastered by the staff (including the assumptions behind those models) in terms of their application ot treatment. How does one "apply" reality-therapy? Is a transactional analysis or gestalt model one which is appropriate for narcotic or barbiturate addicts? In short, do the models selected further the assumptions and philosophy of the treatment program.

The treatment processes constitute the actual treatment program. The question is whether these processes are

relevant and further the objectives of the program. In a Residential Supportive Centre the group process is a socialization, supportive, education/information process which is different from the intensive group process appropriate for a Residential Treatment Centre. Individual, group, marital and family counselling are all processes which are used in a variety of ways, depending on the model.

The staff must have the skills which make treatment happen, such as "empathy", or "confrontation", and the variety of skills needed to pursue the processes listed above. It is an important component of evaluation that staff can demonstrate the skills they are supposed to possess in the pursuit of treatment.

The above description of treatment in relation to program is the outline of a process of staff and program development which can be rigorously pursued and evaluated.

IV. B. WHAT ARE THE MANAGEMENT COMPONENTS OF THE TREATMENT PROCESS?

"Management components" refer to a long list of processes other than the structured or formal treatment process such as: the initial and on-going assessment process, the orientation of the client to treatment and program processes, the client contract, the appropriateness of the physical facility, the staff/client ratio, and the termination procedures. The question implies that the details of management should be consistent with the treatment objectives and that these details may have a positive or negative treatment effect. For some narcotic clients in a methadone program or residents in a half-way house, the way the client is handled may be the major means of making a "treatment" impact. The most usefully designed program will be consistent in the details of both treatment and management.

V. WHAT IS THE STAFF ORGANIZATION AND HOW DOES IT FUNCTION?

Again, there is an extensive list of questions under this section. The first question is particularly critical: what are the staff positions, roles and job descriptions? Staff roles are directly related to program objectives. If a program is not meeting its objectives, the first place to look is the definition of staff roles, particularly the

supervisor. For example, the program director of a residential treatment centre is primarily a treatment person; the individual in this role may do administration, community and industrial relations and liaison work with other agencies, but these are secondary aspects of the role of the program director. One the other hand, the supervisor of a new Out-Patient service may require a greater community development and public relations role in the initial stages of the program.

Other questions are: what are the training needs and staff development processes? how do individual staff members get an evaluation of their job performance? how is the staff itself evaluated as to its effectiveness? what are the treatment and program review processes? how does the staff function in such areas as decision-making, case-work review, use of outside consultants, documentation, liaison with other agencies and developing community awareness of its service?

The last question in this section is one which will require extensive development: how can the staff demonstrate the effectiveness of the program and the skill of the staff? It is important to develop the means for demonstrating that the service for which a program is designed and funded is being

delivered. This demonstration process is for the benefit of treatment staff, in other programs, of administrative or research people, and, not least, of the public which is the source of funding. Demonstration of effectiveness is a sharing, a training and an evaluative exercise.

For an excellent and knowledgeable presentation on the subject of demonstration and evaluation one need only to refer to Dr. Charles Aharan's presentation to the Canadian Foundation on Alcohol and Drug Dependencies 1976 entitled: "Behavioural Therapy Or Persuading People To Be Different".

VI. WHAT IS THE REFERRAL PATH AND THE FOLLOW-UP PROCEDURE?

It is important to know what other resources a program is utilizing, particularly those within the System of Care itself, both for the clients who are completing treatment in a particular program and for those who are assessed as being inappropriate for the program.

Follow-up is a difficult and time-consuming process, yet it is important that some effort be made to determine the outcome of treatment and what happened to the clients after termination of treatment.

After-care is an even more difficult issue, though some components in a System of Care, particularly the Out-Patient Service, can be valuable in developing this phase of treatment.

Having developed a standard way of thinking about treatment programs in the "format" we are in a position to describe the major components of a System of Care. By answering the six "format" questions in the Guidelines we developed a general description of a Detoxication Facility, two Residential Treatment Services which we designated Residential Treatment Programs and Residential Supportive Services and an Out-Patient Service.

Producing the Guidelines

The general program descriptions in the Guidelines were developed from the experience of the two Program Liaison staff in interviewing 150 line workers in most of the service programs in British Columbia during the previous year and a half. Drafts of the Guidelines were sent to the Commission Staff and significant staff people in different types of programs in British Columbia. Program Liaison worked with the Commission to develop the Administrative Section of the Guidelines; the Administrative Section defined the ways in which the Boards or Societies of funded agencies would relate to the Commission and included statements of Commission policy on a variety of issues.

The main point to be made here is that the Guidelines were

developed on the basis of familiarity with the programs and with the concerns of the staff people in these programs. We do not think that a theoretical "system of care" can be effective if it is simply "laid on" a group of programs. It is important that the people for whom the Guidelines are developed participate in that development so that their experience and perspective are utilized. The "format questions" gave us the basis on which we organized that experience.

"The Workbook"

Upon completion of the Guidelines, which became Commission policy for the description of basic components of the System of Care, we developed a 37 question workbook based on the Guidelines. During the next two months the two Program Liaison staff interviewed the staff people of 42 funded agencies; this workbook was the guide for those interviews. At the end of this exercise the Commission had available a comprehensive description of those programs. This material was sent back to the Boards and the Programs so that they had the same information about the service programs that the Commission had. The workbook will be the basis for further discussion between Program Liaison and the programs.

Regional Workshops and Program Description Manual

Four regional workshops were held in December, 1976 and January, 1977. The purpose of these workshops was to introduce the Commission and its policies to the programs in the regions, to discuss the System of Care and its implications for referrals, and to provide an opportunity for staff people to become more familiar with programs in their region. Each program was asked to contribute a brief program description and each program was discussed in detail in small and large groups at the regional workshops. All of these program descriptions were printed in a Program Description Manual for the use of every program in the Province. A revised Program Description Manual produced in the Spring, 1977, became a public document.

Assessment and the Referral Pathway

A basic premise of a System of Care is that a potential client is applying for service to the resources of the whole system and not simply to the program to which he presents himself. Two items are essential in the System of Care: an adequate assessment process and a thorough knowledge of the resources of the System of Care.

Both for initial and on-going treatment and for appropriate

referrals, there is no substitute for an adequate assessment of the potential clients who apply for service. This is an area which will be continuously emphasized in the processes of the System of Care.

The Guidelines and the Program Description Manual, plus the exercises in the regional workshops promote a knowledge of the treatment resources in the region and the province. Further workshops will examine more closely the processes of each program. An important project for future development will be the demonstration of their processes by program staff for other program staff in their own region. The staff people in exemplar programs may be called upon to do both demonstration and training for other program staff in the Province.

Conclusion

We summarize the process of implementing the System of Care in British Columbia as follows:

1. It is important to be familiar with the existing resources and with the people who are already providing the service. The experience of the people who are providing the service is an important resource in developing a System of Care.

2. It is important to conceptualize the framework which will most effectively utilize the available staff experience and treatment resources. This has been done in the "format", in the definition of the major components of the System of Care and in the definition of the lines of communication between the programs and with the administrative body.

3. A System of Care should be a dynamic, growing process with built-in mechanisms of correction and alteration; line staff particularly should be participants in the process of defining, shaping and developing the System of Care.

4. The last point is that treatment is only as effective as the structure which supports it, both at the individual program staff level and at the regional or

provincial level. In effect, every issue in the System of Care is a "treatment" issue; the test of the System is whether it expedites appropriate, effective treatment.